Dealing with prostitution

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Dealing with prostitution in Canada

I take exception to *CMAJ*'s comments about "john school" in a recent editorial.[1] To begin with, the "johns" are in fact exposed to direct feedback about the "public nuisance" aspects of prostitution, from community members whose neighbourhoods are negatively affected by street prostitution. I can assure you that from the community perspective, this problem is far greater than a simple "nuisance."

More important, characterizing john school as a "morality play on prostitution" is inaccurate. We do not try to impose moral standards on the johns. Instead, we leave it up to them to decide if prostitution fits within their own set of socially developed morals and values. We allow them to hear real people's stories about prostitution: police officers who see the damage daily, women who have been there and who are now trying to turn their lives around, a mother who has experienced the heartbreak of seeing her daughter in prostitution, community members who live with prostitution in their neighbourhoods and health care personnel who work with women on the streets. Are there moral issues here? Of course, but the johns are left to decide these issues for themselves.

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Reference

1. Prostitution laws: health risks and hypocrisy [editorial]. *CMAJ* 2004;171(2):109.

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I agree that Canada's prostitution laws need to be revamped, but *CMAJ*'s editorial[1] has missed the point. I'm not convinced that changing the laws will actually make people's lives safer. We need to change attitudes. The police in some cities, such as our own (Edmonton), have made great strides in changing how they enforce existing laws, but we need to look internationally for alternatives to current laws (e.g., Sweden).

There are many disadvantages to decriminalizing prostitution. In particular, there doesn't appear to be much thought going into what decriminalized prostitution would look like. For example, what will the Canadian government do to support those who have no choice about entering prostitution and would in fact prefer not to be in "the trade"?

CMAJ has also missed a concern that lies at its own front door: systematic discrimination from doctors and other health care professionals. Having lived within the trade myself for over a decade and having talked with hundreds of women formerly and currently involved in "the life," I have heard countless stories of judgmental bedside manners by members of the medical profession.

The bottom line is that many women across this country would like to leave the street life, for a variety of reasons. We need to focus on these women and also make it safer for those who choose to remain. We need to get away from the flawed approach of decriminalization, by starting to think about ways of addressing the root causes that lead women to prostitution in the first place.

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Reference

1. Prostitution laws: health risks and hypocrisy [editorial]. *CMAJ* 2004;171(2):109.

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The de facto criminalization of prostitution in Canada is an anachronistic remnant of this society's vigorous early-20th century efforts to assert dominant moral ideology through the force of criminal law; similarly targeted behaviours include select substance use ("illicit drugs") and sexual orientation.[1] However, as *CMAJ*'s editorial wisely outlines,[2] the criminal law is a rather ineffective custodian of moral norms, especially when these are disobeyed by many and disagreed with by many more. Moreover, the ineffective criminalization of private conduct with implications for health can itself produce disastrous consequences, as the excessive human toll of the criminalization of substance use in North America illustrates.[3,4] The prostitution issue is not much different: it is an ancient phenomenon that is here to stay; enforcement interventions are symbolic or of temporary displacement value at best; and the only sensible policy approach must be one grounded in pragmatic principles of public health. As our own research suggests, seemingly benevolent "reform" initiatives like john schools are essentially punishment in disguise for largely lower-class offenders, and thus serve to legitimize the status quo of criminalization rather than reforming it.[5] It is thus a worthy and laudable cause for *CMAJ* to argue for a public health based policy framework to deal with the sex trade issue. It is perhaps unfortunate for the prospects of this call — as also shown by our research — that the public's opinion is more or less divided (as it is on many issues of morality control) on the question of whether sex for money should be controlled by punishment.[6] This matter has thus become a political "no-winner," and law and policy reform will occur only if politicians are pressured to assume proactive and determined leadership, which may be poor in terms of potential vote gains but rich in merit for "good government" and public health.

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[John Lowman responds:]

Contrary to Ian Mitchell's defence of john school, direct observation of the curriculum tells a different story. When Tom Barrett, a journalist, attended john school 4 years ago, one of the pupils asked, "Why doesn't Canada have government-regulated whorehouses?" One of the police officers present replied, "Because people view it as an immoral activity."[1] Another officer told the audience that prostitution is "slavery. They are forced to be there." Canadian research does not substantiate these sweeping claims (see, for example, Benoit and Millar[2]).

Furthermore, there is no evidence that the curriculum has changed in the intervening period. Earlier this year, as part of his honour's degree research, one of my students attended Mitchell's john school and concluded that "the way that sex work is projected is selective and inherently political."[3]

Although the nuisance aspect is on the agenda, the very moniker "john school" gives the game away. The target is the purchase of sex, not the nuisance component. If john school really does let johns decide for themselves, I anticipate that Mitchell will accept my offer to make a regular john school presentation on Canadian prostitution research.

As for Dawn Hodgins' call to help women leave prostitution, such a stance is no reason to abandon the women (and men) who continue to sell sex. One legitimate concern is that decriminalization might trap women in prostitution, with welfare payments being denied to those who want to leave the trade. However, New Zealand's legislation makes it illegal to cut a person off welfare if they refuse to prostitute. At the same time, prostitutes can work in situations where they are not vulnerable to serial killers. In contrast, by ruling out harm reduction strategies, the Swedish approach exposes prostitutes to harm.[4]

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Risks and benefits of β-blockade

P.J. Devereaux and associates[1] state that the current situation with respect to evidence for β-blocker therapy before surgery is similar to the situation that existed 12 years ago when estrogen replacement was widely recommended. I disagree. Estrogen has been implicated in the genesis of many fatal diseases, including breast cancer and thromboembolic diseases.[2,3] The same material risks do not exist for β-blockers. Furthermore, the authors do not disclose or discuss the theoretical or empirical life-threatening risks of β-blockade.

Devereaux and associates[1] also argue that the benefits of preoperative β-blockade in small studies completed to date are "too good to be true." They base this assessment upon the long-term benefits of β-blockade in coronary artery disease and congestive heart failure. However, for these conditions the drugs are administered over long periods, and in combination with many other drugs, to modify the long-term outcome of progressive and often fatal diseases. A more analagous situation is the relative risk of a myocardial infarction induced by another acute stressor, strenuous exercise. One study found that the relative risk of myocardial infarction during or immediately after vigorous exercise was increased 100-fold for habitually sedentary individuals.[4] Most of the patients whom I am asked to see preoperatively are sedentary and thus very likely to benefit from preoperative β-blockade.

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[The authors respond:]

Contrary to Stephen Workman's experience in treating patients perioperatively, our review[1] suggested that the true effects of β-blocker therapy in patients undergoing noncardiac surgery remain uncertain because of a lack of adequately powered, blinded randomized controlled trials (RCTs).

Members of our group recently reported results from a new RCT of perioperative β-blocker therapy.[2] The Metoprololol after Vascular Surgery (MaVS) trial randomly assigned 496 patients undergoing elective vascular surgery to receive metoprolol or placebo starting 2 hours before surgery and continuing for 5 days. This blinded trial is the largest perioperative β-blocker trial reported to date, with more than 4 times as many patients as an unblinded RCT by Poldermans and colleagues[3] of β-blocker therapy for vascular surgery. Those authors reported a statistically significant 90% relative risk reduction with β-